South Dakota Health Care Solutions Coalition

Meeting Notes 10/21/2015

Attendees: Sen. Corey Brown, Brenda Tidball-Zeltinger, Jerilyn Church, Kim Malsam-Rysdon, Willie Bear Shield, Dr. Mary Carpenter, Sunny Colombe, Kathaleen Bad Moccasin, Rep. Justin Cronin, Jason Dilges, Terry Dosch, Scott Duke, Dr. Tad Jacobs, Rep. Don Haggar, Sen. Troy Heinert, Monica Huber, Richard Huff, Charlene Red Thunder, Mark East, Sen. Deb Soholt, Jennifer Stalley, Lynne Valenti, Tony Venhuizen, Sonia Weston, Don Novo, Sara DeCoteau, Sen. Bernie Hunhoff

Welcome and Introductions

Sonia Weston opened with a prayer. Don welcomed coalition members and thanked everyone for their participation.

Overview of Coalition and Review of Minutes

Kim Malsam-Rysdon provided a brief overview of the Coalition's work and the three subcommittees that support it (Access to Services through IHS, New Services, Behavioral Health). There were no questions or comments regarding the minutes from the 10-7-14 meeting.

Medicaid 101 Presentation

Brenda Tidball-Zeltinger, Kim Malsam-Rysdon and Sen. Corey Brown presented information about the South Dakota Medicaid program today, the projected numbers of eligibles and cost of a potential expansion, and the request to the Centers for Medicare and Medicaid Services (CMS) regarding flexibility relative to services provided to individuals eligible for Indian Health Services. (See presentation slides). Understanding the framework of the current program and expenditures for individuals eligible for both Medicaid and Indian Health Services is critical to the work of the coalition and the subcommittees.

In SFY14, South Dakota expended $204 million in total funds for services to individuals also eligible for Indian Health Services. Of that total, $71.2 million was funded at 100% federal match and the remaining $133 million was funded at the state's regular FMAP rate (48% general funds). Kim Malsam-Rysdon and Senator Brown outlined how funding for individuals eligible for both Medicaid and Indian Health Services works and provided several typical examples. Kim noted that the request to CMS to allow the state to claim expenditures at 100% federal match is not new. South Dakota has long argued that when an individual eligible for both Medicaid and Indian Health Services is unable to access care through Indian Health Services for whatever reason, the match rate should be at the 100% federal match rate.

Jason Dilges explained more about the State's net cost of Medicaid expansion. There is a state-by-state view of the specifics of expansion, including one for South Dakota. This view includes an economic analysis of the benefits of expansion, such as additional jobs, gross domestic product, and other economic benefits. The Governor's budget estimates for Medicaid expansion included the revenue impact of several of these economic benefits to establish an overall calculation of the total net State

costs of expansion (the federal match rate changes, the number of individuals added, the take-up rate, etc.), which is an estimated $30 – $33M starting in 2020.

South Dakota has to look at funding expansion a bit differently than states with personal and corporate income taxes, whose state budgets benefit more directly from the economic impact of expansion. Thus the need to identify existing state budget dollars that could be "repurposed" for expansion, and the context of the concept paper to the Centers for Medicare and Medicaid Services (CMS) regarding the federal match rate for services to Native Americans.

Kim Malsam-Rysdon outlined the communication timeline with Health and Human Services and CMS and noted that CMS will be issuing a white paper that will outline its plans for potential policy change in this area. The goal is to identify enough existing funds to support expansion and to improve the quality and access to care for Native Americans in the state. Governor Daugaard wants to be conservative in the projections for expansion and not commit to providing services for which it does not have the money to pay for in the long term. It also is critically important to have support from the Tribes in South Dakota for this to work. Similarly, both the South Dakota Legislature and CMS will need to support the approach and expansion plan effort set forth by the State.

Senator Brown also noted that while CMS flexibility regarding the 100% match rate is a positive step, more importantly change is needed to improve access to health care for Native Americans.

Sonia Weston asked for information regarding the specific changes in eligibility for Medicaid if Medicaid expansion were to occur. The group discussed that the income level for eligibility would increase to 138% and about 48,500 individuals, primarily adults, with or without children would be eligible. About 27% or 13,000 of those projected to be eligible if the state expands, are Native Americans. Sonia suggested this is the information tribes need to share with their members. Individuals also eligible for Indian Health Services that become eligible through an expansion will results in more funding to IHS.

Q& A During/After the Presentation

Q: Of the 133M for Native Americans, is that mostly children (as in the general Medicaid population)? **A:** Yes; Native Americans still have to meet the same Medicaid criteria as anyone else, so the Medicaid-enrolled Native American population looks like the general Medicaid population.

Q: If money is available for IHS PRC, do they pay 100% for that referred care? **A:** It depends on the case. IHS is considered the payer of last resort after insurance or Medicaid. Payment for referred services only applies if the patient lives within the Contract Health Service Delivery Areas CHSDA. For patients that do live within the CHSDA of the providing IHS service unit, funding limitations often result in only Priority 1 or sometimes Priority 2 cases to be referred. **Q:** What percentage of the 48,500 are Native American? **A:** 27%

Q: Will the Medicaid eligibility change for Native Americans? **A:** More Native Americans will be eligible under expansion because the income limits will increase to 138%, and individuals without dependent children will also be covered up to that income level.

Q: What additional benefits for the Tribes? What is the guarantee for improved access for IHS/Tribal Health Organizations? **A:** Increased access to care, access to some new services that are not covered

today, and people who don't have coverage today being eligible are the three big impacts for Tribes. It will be important to communicate these benefits to Tribal members.

Q: Similarly, what's the guarantee of Tribal membership having access to quality healthcare? We have had similar discussions with HHS at the Tribal level for many years with few improvement in access, but not as much with the State. We have support from our Congressional representatives, too. **A:** Expansion provides an opportunity to improve care, and improve health outcomes. 100% FMAP does not increase provider reimbursement, but it does free up IHS direct funding in the IHS budget by shifting the cost of care for Medicaid eligible Native Americans from IHS funding to Medicaid.

Q: This is a great opportunity to improve healthcare in Indian Country. If we are able to shift services to 100% FMAP, that doesn't mean that providers will get paid more, right? **A:** That is correct, 100% FMAP does not increase provider reimbursement, but it does free up IHS funding to the IHS budget by shifting the cost of care for Medicaid eligible Native Americans from IHS funding to Medicaid. The result is more available IHS funding for Native Americans who do not qualify for Medicaid. Additionally, with the increase in the number of insured American Indian patients, the burden of uncompensated care will decrease for non-IHS providers.

Q: There was a discussion at the last meeting about the CHSDAs in North and South Dakota and that there are issues with this structure and access to care. **A:** It is an intricacy within IHS and relates to how IHS allocates PRC dollars. There has been a proposal to create a single CHSDA for both North and South Dakota to simplify access for Tribal members in these areas. The IHCIA, Section 192 establishes a single contract health services delivery area consisting of the states of North Dakota and South Dakota for the purposes of providing contract health care services to members of Indian tribes located in those states. The IHS has not administratively implemented one CHSDA for North and South Dakota purposes of the CHS program due to funding limitations. The tribes would request that the IHS to follow the provision of Section 192 of the IHCIA, with savings from referrals deferred to non-IHS providers.

Subcommittee Reports

The Increasing Access to Services Provided through Indian Health Services subcommittee has a number of representatives from the larger Coalition, as well as the large health systems, and other providers, FQHCs, etc. The goal is to increase access to care through IHS/Tribal Health Organizations through some creative ideas and partnerships between IHS/Tribal Health Organizations and other providers in the State. These services would be eligible for 100% FMAP from CMS, as well as target specific care needs within IHS/Tribal Health Organizations.

There was a very robust discussion at the last meeting, with an agreement from providers to come back to the table with specific ideas relative to telehealth and other partnerships that increase access to specialized services. The goal is to expand services provided locally through IHS/Tribal Health Organizations. IHS also is to look at what services are really needed that could be provided through their service sites. There also are questions about how to implement these ideas and to address the challenges and barriers relative to some of the processes used to facilitate these arrangements. For example, streamlining the contracting and credentialing process within IHS and addressing discrepancies between IHS and Medicaid such as pharmacy formularies.

Senator Heinert noted that when we talk about $443M in State spending about 46% of that is spent on Native Americans, even though they are only 35% of the Medicaid population. It means that Native Americans are getting sicker and costing more. This discussion is critical so that this issue can be addressed and providers, IHS, tribes must all come together with ideas to make this work.

The subcommittee is focusing on telemedicine as one approach as South Dakota has been doing telemedicine for many years. For example, care for pregnant women via telehealth has been available here in South Dakota since 1993. There are other providers who are looking at other types of partnerships between providers in support of pregnant women and children in general. The South Dakota Dept. of Health has been working for a long time on improving quality and outcomes for pregnant women and babies. This is a big focus area with a lot of support that we could leverage. OB/GYN is a key service that the Access to Care subcommittee can really focus on.

The *New Services Workgroup* is being formed; the membership list should be finalized this week (10/23). This group will focus on two key ideas for new Medicaid services: leveraging the Community Health Representative model (CHRs) and discussing Medication Therapy Management services. Both of these services have the potential for significant impact on costs and quality of care. There will be an organizing call next Wednesday (10/28), 3 – 4 p. m.Central time.

The *Behavioral Health Subcommittee* membership also will be finalized soon. The starting point for this group will focus on understanding the community mental health system for Medicaid today. There has not been a meeting scheduled yet, but the goal is to start in the next couple of weeks.

There will be some overlap between these groups, but we are going to keep each focused on their specific charges as much as possible.

Update on Conversation with CMS

Kim Malsam-Rysdon provided an update on the communication with CMS. The State continues to be very encouraged that CMS is seriously considering changes at the federal level that would benefit both South Dakota, as well as all other states. CMS specifically discussed feedback they have gotten from Tribes and other stakeholders that people still have access to their providers and that there is an emphasis on care coordination. They alluded to the fact that any changes they make will still need to be connected to IHS and the Tribal Health Organizations. CMS intends to release a white paper “soon” for states and Tribes to provide comment – although they will likely only have a two –week window for comment. They specifically asked South Dakota to review the white paper and ensure it addresses the State’s request. The State will make sure that people know when the white paper is released and can submit comments. Once CMS gets feedback, they will issue a State Health Officer (SHO) letter to implement the policy changes, which allows them to implement changes much faster.

On a national level, Jerilyn Church shared the Tribes are advocating that there be a very broad interpretation of how the 100% FMAP is applied and the services it will cover. The Tribes want to make sure that the new policy is not so narrow it restricts Tribes’ ability to deliver services they need/can deliver.

The second call with CMS included more discussion of the need for care coordination and that there will likely be some level of care coordination requirements related to expanding the 100% FMAP for more

services. The Coalition should think about how to improve and enhance care coordination. The Medicaid Health Home project is a good model to start with and perhaps replicate.

Care Coordination:

Given the CMS focus on care coordination and the potential health home core services has to increase access to care, the group discussed leveraging aspects of the current health home program for future care coordination efforts. The group discussed a health home program overview for the next meeting. Another suggested discussion item for the next meeting was information regarding how care coordination happens in IHS today including how records are shared, and how are patients tracked across providers.

The New Services Subcommitee will be discussing the role Community Health Representatives play in care coordination, particularly in helping with non-medical needs and connecting people to the health care system. The subcommittee will be discussing information about this and bring these concepts back to the larger group. In addition, the Medicaid Tribal Consultation process is focusing and learning more about how some of the Tribes implement Community Health Representative services, as well as what Medicaid covers today. In Cheyenne River, the CHRs are CNAs, so they can provide an array of basic services. It will be good to understand what the differences are between CHRs and public health nurses in IHS/Tribal Health Organizations and non-his providers, including how they are supervised, what training they have, and what roles and responsibilities they have.

There are some good ideas to work with for our next meeting regarding CHRs/CHWs and how they can support care coordination as well as how other states including Alaska, North Dakota, Arizona, New Mexico, Oklahoma utilize these care models.

Next Meeting

Wednesday, November 4, 1 – 3 p.m., Ramkota, Gallery D